COORDINATION OF BENEFITS FORM

MEMBER INFORMATION

Member Name ____________________________ SS#______________________

Address: _______________________________ Telephone No. _____________

_______________________________ Date of Birth____/_____/____

_______________________________ Marital Status ( )Single ( )Married
( )Divorced ( )Domestic Partner
( )Widowed Date ___/____/____

SPOUSE/DOMESTIC PARTNER INFORMATION

Name ______________________ SS#__________________ Date of Birth ___/___/____

DEPENDENT INFORMATION

Name of Eligible Dependent	Date of Birth	Social Security Number
_________________________	___/_____/___	_______________________
_________________________	___/____ /____	_______________________
_________________________	___/_____/____	________________________

HEALTH PLAN AND WELFARE FUND INFORMATION

Name of **Your** Current Health Plan ________________________________

Are **you** covered by another health plan? ( )Yes ( ) No
If "yes" indicate name of Plan ______________________________.

Is **your spouse/domestic partner** covered by another health plan? ( )Yes ( ) No
If "yes" indicate name of Plan ______________________________.

Are **you** covered by another drug plan? ( )Yes ( ) No
If "yes" indicate name of Plan _____________________.

Is **your spouse/domestic partner** covered by another drug plan? ( ) Yes ( ) No
If "yes" indicate name of Plan ______________________.

(over)

Are **you** covered by another dental plan? ( )Yes ( ) No
If "yes" indicate name of Plan ______________________.

Is **your spouse/domestic partner** covered by another dental plan? ( ) Yes ( ) No
If "yes" indicate name of Plan _____________________.

Are **you** covered under Medicare? ( ) Yes ( ) No
If "yes" indicate effective date ___/____/____.

Is **your spouse/domestic partner** covered under Medicare? ( ) Yes ( ) No
If "yes" indicate effective date ___/____/____.

Are any of **your eligible dependents** covered under Medicare? ( ) Yes ( ) No
If "yes" indicate effective date ____/____/_____.